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INVITED COMMENTARY

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The authors compared the suitability for endovascular repair (EVAR) in patients with incidentally diagnosed and screen-detected aneurysms. In view of the potential effects on the future health economics of aneurysm screening and EVAR, this is a topic of considerable interest. The study was initiated after the authors' observation that screen-detected aneurysms tended to have longer infrarenal necks. However, early abdominal aortic aneurysm (AAA) detection did not lead to an increase in suitability for EVAR in this study.

Before the outcome of this study is accepted, several issues must be addressed. First, the study lacks a proper power analysis, and with recruitment arms of 41 and 31 patients, a type II error is imminent. One may further question the efficacy of the ultrasound screening program to which the study population was exposed, because the median aneurysm diameter upon referral was 65 mm (range, 51-79 mm), after a mean of nine surveillance scans per patient, typically spanning a minimum of 2 years. As a result, the screen-detected aneurysms were relatively large at the time of referral, whereas EVAR suitability is expected to be higher in smaller AAAs. The study was conducted in a vascular center where EVAR is not offered as a treatment option, and all patients underwent open repair. Presumably, a center with little or no EVAR experience will tend to use rather rigid criteria for this treatment option as compared with EVAR centers. Common indications for surgery were applied in this study: aneurysm diameter larger than 55 mm, rapid expansion of more than 10 mm/y, or a tender aneurysm. This is in accordance with most EVAR studies. The determination of suitability for EVAR, however, depended on the—rather poorly defined—manufacturer's criteria for a single device, whereas in most endovascular programs, EVAR eligibility is determined on the basis of the availability of multiple devices. In addition, suitability for EVAR is never an objective qualification, irrespective of manufacturer's guidelines, which are commonly rather conservative (for understandable reasons). Many clinicians, for instance, consider neck thrombus not to be a contraindication to EVAR, although this was the second most common exclusion criterion in this study. This may be an explanation for the low rates of suitability for EVAR of 41% and 45% in the screen-detected and incidentally diagnosed AAAs, respectively, whereas in many centers 60% of AAA patients receive an endograft. It is quite possible that with more liberal criteria for EVAR, screen-detected aneurysms would have shown a higher suitability rate than the incidentally diagnosed aneurysms. Caution is therefore appropriate in the interpretation and generalization of the outcome of this study.